Pennsylvania's STATE SYSTEM of Higher Education

COBRA Enrollment/Change Form

*Qualifying life events – form must be returned within **60 days of event.***
(see link below or click here for qualifying events information)

CHANGE REASON(S)

☐ ADD SPOUSE/DEPENDENTS - INDICATE REASON IN REMARKS SECTION
☐ REMOVE SPOUSE/DEPENDENTS - INDICATE REASON IN REMARKS SECTION
☐ CANCEL COVERAGE
☐ CHANGE – INDICATE REASON IN REMARKS SECTION

COBRA OPEN ENROLLMENT	GROUP #	BARGAINING UNIT	PERSONNEL #	EFFECTIVE DATE
				7/1/2025

EMPLOYEE DEMOGRAPHIC INFORMATION

HEALTH PLAN CHOICES:	SUPPLEMENTAL BENEFITS (DENTAL and VISION – not applicable to Faculty)
☐ PPO PLAN ☐ UPMC (Changes to current participants only, no new enrollments) ☐ WAIVE MEDICAL BENEFITS	☐ SUPPLEMENTAL BENEFITS ☐ WAIVE SUPPLEMENTAL BENEFITS

SOCIAL SECURITY #	EMPLOYEE NAME	DATE OF BIRTH (MM/DD/YYYY)

STREET ADDRESS	CITY	STATE	ZIP CODE

COUNTY	RELATIONSHIP STATUS	DATE OF MARRIAGE/ DOM. PARTNERSHIP	DATE OF DIVORCE/ TERM OF DOM.PARTNERSHIP	DAYTIME PHONE #
	☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ SAME-SEX DOMESTIC PARTNER			

DEPENDENT DATA

ADD/REMOVE	DEPENDENT NAME	DATE OF BIRTH (MM/DD/YYYY)	SOCIAL SECURITY #
☐ ☐	SPOUSE ☐ DOMESTIC PARTNER ☐ Name: Gender:		
☐ ☐	SON ☐ DAU ☐ OTHER ☐ (Explain Relationship) Name: Gender:		
☐ ☐	SON ☐ DAU ☐ OTHER ☐ (Explain Relationship) Name: Gender:		
☐ ☐	SON ☐ DAU ☐ OTHER ☐ (Explain Relationship) Name: Gender:		
☐ ☐	SON ☐ DAU ☐ OTHER ☐ (Explain Relationship) Name: Gender:		

OTHER COVERAGE DATA

Does your spouse/Domestic Partner have other State System of Higher Education health coverage?
☐ YES ☐ NO
Do you or your dependents have other health coverage?
☐ YES ☐ NO If yes, provide the following information:

Full Name of Insured	Name of Health Care Plan/Insurance Co.	Policy/ID Number

REMARKS:

AUTHORIZATION FOR APPLICATION FOR ENROLLMENT: I request the above enrollment (or change) for insurance coverage. I hereby apply for the coverage indicated. ***I understand no changes can be made to this coverage except during Open Enrollment, or when a qualified life event occurs.*** I also understand this application is subject to approval by the Plans, and my coverage will be subject to the terms of the agreement issued to the Pennsylvania State System of Higher Education Health Care Programs. Any person or operation having provided or who may provide health care services to me or any person named on this application either prior to or during this contract is authorized to furnish to the Plans any information or records relating to these services. Any person who knowingly and with intent to defraud any insurance company or other person who files an application for insurance or statement or claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. ***I understand that I may be personally liable for any claims paid on behalf of an ineligible dependent.***

EMPLOYEE	DATE (MM/DD/YYYY)	HUMAN RESOURCES USE ONLY (FULL CLOCK #)

Dependent eligibility documents - https://www.passhe.edu/hr/benefits/documents/benefit-summaries/sshe-summary.pdf#page=15

Qualifying Event Information - https://www.passhe.edu/hr/benefits/documents/benefit-summaries/sshe-summary.pdf#page=18